DMHC use only

Call Ref. # _____

CONSUMER COMPLAINT FORM

Complete this form only if you have completed the formal grievance/appeal process with your health plan and are not satisfied with the resolution or if your health plan did not resolve your grievance within 30 days. ***However, if your complaint involves an imminent and serious threat to the health of the patient, immediately contact the HMO Help Line toll free at (888) HMO-2219 or TDD (877) 688-9891.*** **Please type or print clearly.**

1. **Complainant's Name:** _____
   Street Address: _____
   City: _____ **State:** _____ **Zip:** _____
   Telephone: (Daytime): _____ (Evening): _____
   Cell Phone: _____ **E-mail Address:** _____

2. **Patient's Name and Address: (Only if different from Complainant):**
   ☐ _____
   ☐ _____
   _____

3. **Health Plan Name:** _____
   Medical Group Name: _____
   Medical Group #: _____
   Patient's ID # (or Membership #): _____
   Patient's Date of Birth: _____

4. **Are you a Medi-Cal Beneficiary?** **Yes** ☐ **No** ☐
   Are you a Medicare Beneficiary? **Yes** ☐ **No** ☐

5. **Have you previously filed a formal grievance/appeal with your health plan regarding this complaint?**

   If <u>YES</u>, date(s) of contact: _____
   Person(s) contacted: _____
   Telephone: _____

   If <u>NO</u>, you must first complete the formal grievance/appeal process with your health plan (see Consumer Complaint Process section "How Does the Complaint Process Work?").

6. Please fully explain the essential facts of this complaint. What health plan service did you not receive? What was wrong with the service received? What billing issues do you have? Explain who, what, where, when, and how. Please attach photocopies of any correspondence you received from the plan, and any other documents that you believe support your complaint. Attach additional paper, if more space is needed. (Dates of Service & Provider Information are required.)

_____
_____
_____
_____
_____
_____
_____
_____
_____

7. If your complaint involves care or treatment provided by an individual provider (i.e., a doctor, nurse, or dentist), do you authorize the DMHC to forward this complaint to the agency that has jurisdiction?
Yes ☐ No ☐

8. What is your diagnosis related to this complaint? _____
_____

9. What treatment(s) have you received related to this complaint?
_____
_____

10. Have you reported this to any other government agency?
Yes ☐ No ☐
Agency and file number *(if known)*:
Agency _____ **File Number** _____

11. Is there a lawsuit pending? Yes ☐ No ☐
If yes, attach a photocopy of the court documents and provide:
Name of the County where filed: _____
Case Number: _____ **Date Filed:** _____
Name of Representing Attorney: _____
Telephone: _____

I understand that providing the information is not mandatory, but failure to do so may delay or even prevent further consideration of a resolution on my complaint. I understand that a copy of this complaint may be sent to my health plan.

_____ _____

Signature of Complainant **Date**

_____ _____

Signature of Patient, if adult **Date**

If you have any questions or need assistance completing this form, call our HMO Help Line toll free at (888) HMO-2219 or TDD (877) 688-9891.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

_____ ***on behalf of*** _____
Person Authorizing Release **Patient**

hereby authorize _____
Health Plan

to release to the Department of Managed Health Care (Department) the medical record(s) in the custody and/or control of the Health Plan, including applicable mental health records, concerning care provided to the patient relating to the Complaint filed with the Department.

This authorization for release of information may be revoked or withdrawn at any time and revocation or withdrawal will apply to all information not previously released to the Department. This authorization will expire one year following the date indicated below and the expiration will apply to all information not previously released to the Department. Your medical records will only be obtained if it is determined to be necessary in order to complete a review of your Complaint. This information will be kept confidential.

THIS MEDICAL AUTHORIZATION IS NOT MANDATORY. HOWEVER, FAILURE TO SIGN THIS RELEASE MAY PREVENT FURTHER ASSISTANCE ON YOUR COMPLAINT.

_____ _____
Signature of Complainant **Date**

_____ _____
Signature of Patient, if adult **Date**

If completing on behalf of another adult, a signature is required from that individual. If you have Power of Attorney on behalf of another individual, please provide us with a copy of the legal document.

Please sign the Complaint Form and the Authorization for Release of Medical Records. Attach photocopies of all relevant documents and records, as originals cannot be returned.

Fax these documents to: **(916) 229-0465** **or**

Mail to: **Department of Managed Health Care**
California HMO Help Center
980 Ninth Street, Suite 500
Sacramento, CA 95814